



Policy matters

National Trends in Health Insurance Coverage of Pregnant and Reproductive-Age Women, 2000 to 2009

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A B S T R A C T

Purpose: Health insurance facilitates financial access to health services, including prenatal and preconception care. This study characterized changes in health insurance coverage among reproductive-age women in the United States from 2000 to 2009.

Methods: Data from female respondents (ages 18–49) to the National Health Interview Surveys, 2000 to 2009 ($n = 207,968$), including those pregnant when surveyed ($n = 3,204$), were used in a repeated cross-sectional design. Changes over time were estimated using longitudinal regression models.

Main Findings: Of the reproductive-age women in this study, 25% were uninsured at some point in the prior year. Ten percent of pregnant women reported currently being uninsured, and 27% and 58% reported Medicaid coverage or private health insurance, respectively. Among women who were not pregnant, 19% were currently uninsured, 8% had Medicaid, and 68% had private coverage. From 2000 to 2009, an increasing percentage of reproductive-age women reported having gone without health insurance in the past year. Controlling for sociodemographic and health variables, the chances that a reproductive-age woman had been uninsured increased by approximately 1.5% annually ($p < .001$), and did not differ between pregnant women and those who were not pregnant. The odds that an insured pregnant woman had Medicaid coverage increased 7% per year over the study period ($p < .001$), whereas the odds of private coverage decreased.

Conclusion: Reproductive-age women are increasingly at risk of being uninsured, which raises concerns about access to prenatal and preconception care. Among pregnant women, access to private health insurance has decreased, and state Medicaid programs have covered a growing percentage of women. Health reform will likely impact future trends.

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Introduction

The public health importance of access to health care for reproductive-age women, including preconception and prenatal care, has motivated national goal setting as well as policy agendas and discussions (Rosenbaum, 2008; U.S. Department of Health and Human Services, 2010). Starting in 1991, all state Medicaid programs were required to cover pregnant women with incomes below 133% of the federal poverty level (FPL), and by 2008, 20 states covered pregnant women up to at least 200% of the FPL (Glied, Jack, & Rachlin, 2008; Kaiser Family Foundation,

2010a). As of 2005, 41% of all births in the United States were financed through Medicaid (Kaiser Family Foundation, 2010b). There have been recent policy efforts to expand health insurance coverage for pregnant and reproductive-age women through state Medicaid programs, the Children's Health Insurance Program Reauthorization Act of 2009, and incentives and structures introduced in the context of the Affordable Care Act (ACA) of 2010 (Howell, 2001; Johnson, 2010; Markus & Rosenbaum, 2010; Sakala, 2010). Key provisions of the ACA most likely to affect health insurance coverage for women of reproductive-age include Medicaid expansions to cover low-income individuals (<133% FPL), state-based exchanges for the purchase of private health insurance with premium subsidies for those between 133% and 400% FPL, zero cost-sharing for certain preventive services including prenatal visits, elimination of preexisting condition exclusions, and an individual mandate to purchase health insurance. (Kaiser Family Foundation, 2010b; Johnson, 2010; Sakala, 2010).

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The past decade has seen a general rise in rates of uninsurance and a decline in private health insurance and employer-sponsored coverage (DeNavas-Walt, Proctor, & Smith, 2010; Kaiser Family Foundation and Health Research and Educational Trust, 2010). However, the extent to which pregnant and reproductive-age women have been affected has not been documented. The most recent study of trends in health insurance among American women showed an increasing rate of uninsurance, growing from 11.7% in 1980 to 18.2% in 2005 among women ages 25 to 64 (Glied et al., 2008). More recent data on changes in health insurance coverage, as well as analyses focusing specifically on pregnant women, are lacking.

Health insurance provides childbearing women with greater financial access to timely care before and during pregnancy, which promotes the health and well-being of mothers and their babies (U.S. Centers for Disease Control and Prevention [CDC], 2006). Lack of health insurance can be a barrier to accessing appropriate care for pregnant and childbearing women; it can lead to delays, forgone care, and poor health outcomes (Hadley, 2003; Kaestner, 1999; Oberg, Lia-Hoagberg, Skovholt, Hodkinson, & Vanman, 2010).

This paper examines recent trends in health insurance coverage among women of reproductive age (ages 18–49) in the United States, with particular attention paid to changes occurring in health insurance coverage of pregnant women. Our goal was to characterize pre-health reform trends in health insurance for reproductive-age women, including those who are pregnant, and to understand the implications of prior trends for the implementation of the ACA.

Methods

This study used recent (2000–2009), nationally representative survey data in a repeat, cross-sectional design to examine changes over time in health insurance coverage among pregnant and reproductive-age women.

Data and Study Population

The study population was drawn from the Integrated Health Interview Series (IHIS), a web-based harmonization of data from the U.S. National Health Interview Surveys (NHIS), which are conducted annually by the CDC among a population-based, representative sample of noninstitutionalized Americans (IHIS, 2010). Detailed information about the survey methodology, variable measurement, and data harmonization is available on the IHIS website (<http://www.ihis.us/ihis>). These data have been successfully used in epidemiologic and health services research to document trends in health behaviors and health care utilization. The IHIS data are also useful for conducting policy-relevant, longitudinal analyses of health-related outcomes (Johnson, Blewett, Ruggles, Davern, & King, 2008). We analyzed survey responses from 2000 to 2009 from all female participants ages 18 to 49 ($n = 207,968$), including those who reported being pregnant at the time of the survey ($n = 3,204$).

Variable Measurement

Health insurance coverage was measured from both current and retrospective perspectives. Survey respondents were asked whether they currently had health insurance on the date the survey was administered, and they were also asked to identify the type of insurance coverage they had. We categorized

respondents as either insured or uninsured, and among those with health insurance, we created indicator variables for whether the respondent reported Medicaid coverage or private health insurance. We also created a variable to indicate whether the respondent reported currently having access to health insurance at work. Survey respondents with insurance coverage were also asked about having experienced any time without health insurance over the past year, and we created a variable to indicate whether a respondent was either currently uninsured or reported having been uninsured at any point in the year before responding to the survey.

During the survey administration, female respondents were asked whether they were currently pregnant. Thus, we were able to distinguish pregnant women from nonpregnant women. However, the survey did not collect information on other pregnancy-related variables such as gestational age.

We included the following variables as demographic or socioeconomic controls, because they are associated with health insurance access and coverage: Age (in years), U.S. citizenship, race, ethnicity, marital status, family size, level of educational attainment, employment status, family income below the FPL, health status, and region of the country. Variables were constructed based on respondents' self-reports at the time of the survey and have been used in prior research utilizing NHIS and IHIS survey data (Blewett, Johnson, & Mach, 2010; Johnson et al., 2008). Although all race and ethnicity categories are included in statistical analyses, fewer than 5% of all women in the sample identified themselves as Asian, Native American/American Indian, multiracial, and other. Thus, sample size was not sufficient for calculation of statistically meaningful differences among these racial groups. Results for Black (vs. White) race and Hispanic (vs. not Hispanic) ethnicity are shown in Tables 1 and 2.

Statistical Analysis

We calculated descriptive statistics to characterize the study population and presented differences between pregnant women and those of reproductive age who were not pregnant. Changes over time were estimated using a series of regression models for whether the respondent reported going without health insurance at any time in the past 12 months, whether she was currently insured, and whether health insurance was available to her through work. These regressions were conducted using generalized linear models with a logit link, given the dichotomous outcomes under study in this analysis, and we modeled longitudinal change over time by year (Fitzmaurice, Laird, & Ware, 2004). Conditional regression models were used to estimate changes over time in the odds of Medicaid coverage versus private insurance among women who reported being insured.

Sampling weights were used in analysis to reflect the survey methodology, and weights were adjusted to account for pooling 10 years of data. We estimated regression models for key outcomes for pregnant women and for nonpregnant women separately. To compare trends for pregnant women with reproductive-age women who were not pregnant, we estimated models with interaction terms to test whether patterns of insurance coverage over time differed between the two groups.

Results

Of the pregnant women in this study, 10% reported currently being uninsured, whereas 27% and 58% reported Medicaid coverage or private health insurance, respectively (Table 1).

Table 1
Descriptive Statistics for U.S. Women (Aged 18–49), 2000 to 2009

	Pregnant Women (n = 3,204)		Women Who are Not Pregnant (n = 204,764)	
	n	%	n	%
Outcomes = health insurance status				
Ever uninsured (in past year)	793	25	49,817	24
Currently uninsured	329	10	39,473	19
Currently insured through Medicaid	854	27	16,901	8
Currently privately insured	1,853	58	139,092	68
Currently offered health insurance at work	1,263	39	93,518	46
Covariates				
Age (yrs)				
<25	996	31	42,738	21
25–29	945	29	29,365	14
30–34	774	24	30,125	15
≥35	490	15	102,536	50
Race/ethnicity				
Hispanic	600	19	29,749	15
Black	491	15	28,478	14
≥4-Person family	949	30	91,285	45
Married	2,180	68	110,577	54
Working	1,708	53	137,386	67
U.S. citizen	2,758	86	183,087	89
Education				
Less than high school	560	17	25,833	13
High school	1,600	50	112,128	55
College	621	19	37,906	19
Graduate degree	299	9	14,910	7
Poor or bad health	139	4	14,895	7
Family income below the federal poverty level	515	16	21,576	11
Region				
Northeast	549	17	37,419	18
North central	767	24	48,395	24
South	1,226	38	74,853	37
West	662	21	42,278	21

Nearly 40% were offered health insurance coverage at work. On average, over the past decade, about 25% of pregnant women in this study were either currently uninsured or uninsured at some point in the prior year. This figure was nearly the same for reproductive-age American women who were not pregnant (24%).

Among 18- to 49-year-old women who were not pregnant, 19% had no health insurance, 8% had Medicaid coverage, and 68% had private coverage. Approximately 46% received an offer of health insurance from their employer. Demographic and socioeconomic characteristics that were broadly similar among pregnant and nonpregnant women included race/ethnicity, citizenship status, educational attainment, and region of the country. Pregnant women were, on average, younger, more likely to be married, have smaller families, and less likely to be working than women who were not pregnant. Pregnant women were more likely than nonpregnant women to have a family income less than the FPL, but nonpregnant women more often reported being in poor or fair health.

Unadjusted trends over time in current health insurance status are shown in Figure 1, and distinguish between pregnant women (solid lines) and those who were not pregnant (dashed lines). There are differences in both levels and trends of coverage, with lower overall levels of private coverage and of uninsurance among pregnant women and higher levels of Medicaid coverage among pregnant women, compared with women who were not

Table 2
Results from Logistic Regression Models for Current Health Insurance Status among Pregnant Women (n = 3,204) from 2000 to 2009

	Currently Uninsured		Currently Covered by Medicaid (Conditional on Having Insurance; n = 2,785)	
	OR	95% CI	OR	95% CI
Trend over time (annual)				
Year (2000–2009)	0.97	0.91–1.03	1.07	1.02–1.120*
Demographic characteristics				
Age (in years)	1.00	0.98–1.01	0.94	0.91–0.960†
Hispanic (vs. non-Hispanic)	1.55	1.15–2.10†	1.32	0.89–1.97
Black (vs. White)	1.02	0.57–1.81	1.12	0.80–1.59
Family of ≥4	0.75	0.63–0.90*	1.41	0.56–3.51
Married (vs. not married)	0.75	0.56–1.00‡	0.23	0.18–0.31†
Working (vs. not working)	0.79	0.74–0.85†	0.40	0.35–0.46†
US citizen	0.26	0.18–0.37†	0.57	0.37–0.89‡
High school (vs. less than high school)	0.73	0.61–0.87‡	0.60	0.39–0.92‡
College (vs. less than high school)	0.34	0.25–0.47†	0.13	0.10–0.18†
Graduate degree (vs. less than high school)	0.10	0.04–0.26†	0.17	0.09–0.31†
North Central (vs. North East)	1.48	0.52–4.18	1.04	0.67–1.59
South (vs. North East)	2.16	1.09–4.31†	1.12	0.65–1.91
West (vs. North East)	1.25	0.60–2.60	1.09	0.92–1.29†
Self-reported fair or poor health	0.51	0.39–0.66†	1.60	1.06–2.41†
Family income less than the federal poverty level	1.37	1.05–1.79†	6.30	6.06–6.55†

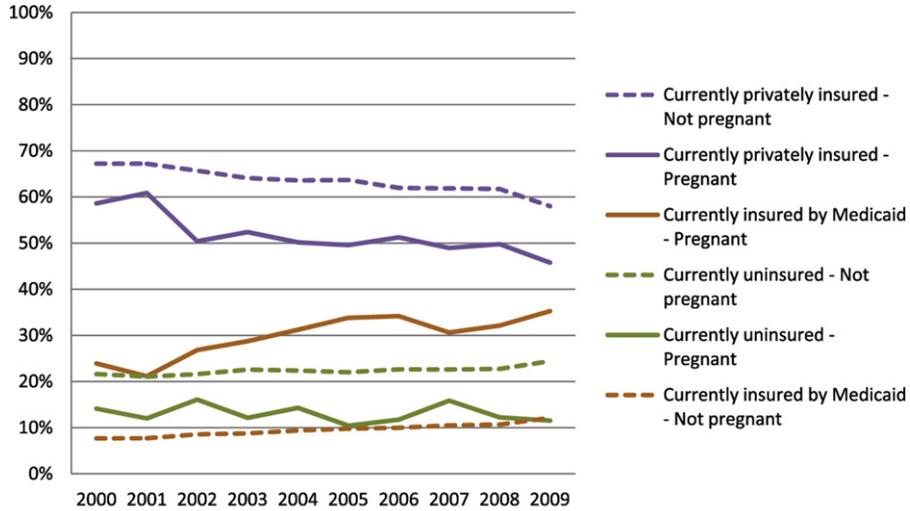
* $p < .01$.† $p < .001$.‡ $p < .05$.

pregnant. Both pregnant and nonpregnant women saw declines in private health insurance coverage, but pregnant women reported increases over time in Medicaid coverage (although this remained steady for nonpregnant women), and no changes in current uninsurance (which increased for nonpregnant women).

After controlling for age, citizenship, race, ethnicity, family size, marital status, education, health status, poverty, employment, and region of the country, trends identified in Figure 1 were examined for significance. Table 2 presents the results from adjusted regression models for current health insurance status among pregnant women. The odds that a pregnant woman was uninsured do not change over the study period. Our data indicate that Hispanic women, those living in the South (relative to the North East), and those with a family income below the FPL have increased odds of uninsurance. Factors that indicate a higher likelihood of having health insurance among pregnant women include large family size (≥4), being married, working, U.S. citizenship, and having higher levels of education.

Among pregnant women with insurance, the odds of being currently insured by Medicaid increased by 7% per year over the study period ($p < .001$). Younger, unmarried women, those who were not working, non-citizens, those with less education, those in fair or poor health, and those with family income less than the FPL were more likely to have Medicaid coverage during their pregnancy (relative to private coverage).

Some women have access to employer-sponsored health insurance, either through their own job or through a spouse. In this analysis, data were not available on access to employer-sponsored health insurance through spousal coverage. The availability of employer-based health insurance through their own jobs decreased over the study period for all reproductive-age



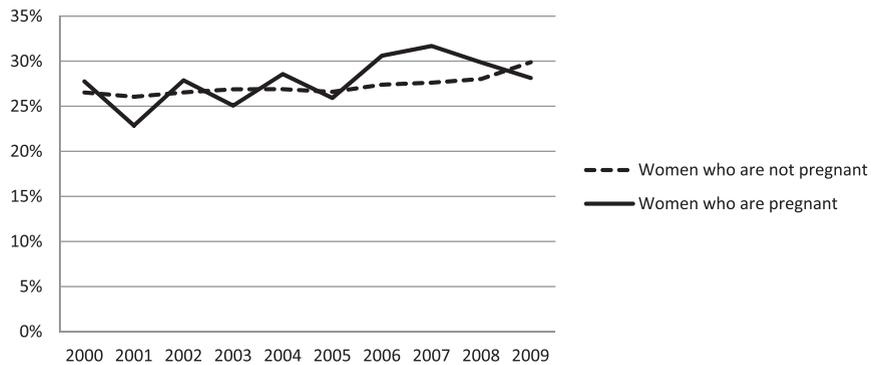
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	% change
Pregnant											
Private	59%	61%	50%	52%	50%	50%	51%	49%	50%	46%	-22%
Medicaid	24%	21%	27%	29%	31%	34%	34%	31%	32%	35%	47%
Uninsured	14%	12%	16%	12%	14%	10%	12%	16%	12%	12%	-18%
Not pregnant											
Private	67%	67%	66%	64%	64%	64%	62%	62%	62%	58%	-14%
Medicaid	8%	8%	9%	9%	9%	10%	10%	11%	11%	12%	58%
Uninsured	22%	21%	22%	23%	22%	22%	23%	23%	23%	24%	13%

Figure 1. Trends (2000–2009) in current health insurance coverage among U.S. women ages 18 to 49, stratified by pregnancy status.

women. A lower percentage of pregnant women reported being currently employed (53% vs. 67% of nonpregnant women), and thus fewer had health insurance available to them through their own employer. The trends over time in access to health insurance through work were similar for women who were pregnant and those who were not. Women’s access to health insurance through their employers fell from 38% in 2000 to 34% in 2009 among pregnant women and from 46% to 41% among nonpregnant women (results not shown).

From 2000 to 2009, there was an increasing trend in the percentage of women of reproductive age who reported having

gone without health insurance at some point in the past year (Figure 2). Controlling for demographic and socioeconomic variables, the chances that an 18- to 49-year-old woman either was or had been uninsured increased 1.5% annually ($p < .001$) over the study period; this trend was not different for those who were pregnant compared with those who were not. Among expectant mothers who reported having been uninsured at some point in the previous year, the chances of being currently insured by Medicaid increased (3% annually), although the change was not significant at conventional levels, and the sample size was limited for this estimation.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	% change
Pregnant	28%	23%	28%	25%	29%	26%	31%	32%	30%	28%	1%
Not pregnant	27%	26%	27%	27%	27%	27%	27%	28%	28%	30%	13%

Figure 2. Trends (2000–2009) in the percentage of U.S. women (ages 18–49) who reported being currently or formerly uninsured in the past year, stratified by pregnancy status.

Discussion

A number of striking findings emerged from this analysis. Approximately 1 in 4 women of childbearing age reported currently being or having been uninsured at some point in the past 12 months, and this number grew over the past decade. Rates of uninsurance have risen in recent years among all reproductive-age women, including those who were uninsured before pregnancy. This represents a significant potential barrier to accessing appropriate prenatal and preconception care (Egarter, Braveman, & Marchi, 2002; Rosenbaum, 2008; Wise, 2008). Trends in prior uninsurance seemed to diverge slightly (although not significantly) between pregnant and nonpregnant women during 2006 and 2007. This is likely owing to random sampling variation; we identified no major policy interventions that would have produced such a shift. However, these trends may have contributed to national efforts to highlight the importance of preconception care (Rosenbaum, 2008; Wise, 2008). Overall, the growing number of reproductive-age women who experienced uninsurance is concerning; however, it is consistent with prior research. Our findings reflect similar published results which estimate the percentage of adult women under 65 without health insurance at 18.2% in 2005 and 17% in 2008; further, in 2008, 24% of all women ages 18 to 64 reported having gone without insurance at some point in the prior year (Glied et al., 2008; Ranji & Salganicoff, 2011).

Although there is great variability in eligibility and enrollment procedures, coverage policies, and benefits structures across state Medicaid programs and over time (Heberlein, Brooks, Guyer, Artiga, & Stephens, 2011; Kaiser Family Foundation, 2010a; Ranji, Salganicoff, Stewart, Cox, & Doamekpor, 2009), our analysis indicates that state Medicaid programs have been increasingly covering pregnant women, including those who reported having previously been uninsured. Table 3 presents examples of state-level Medicaid policies that affect insurance coverage for pregnant and reproductive-age women and information on variations in state adoption of such policies. Particularly influential policies are summarized briefly below and described in depth elsewhere. (See, for example, Heberlein et al., 2011; Hill

et al., 2009; Ranji et al., 2009). As a condition for receiving federal matching dollars, state Medicaid programs are required to cover pregnant women up to at least 133% FPL, but some states currently cover pregnant women up to 300% FPL (Kaiser Family Foundation, 2011a). Income eligibility levels for pregnant women are determined by states and have generally remained steady or increased slightly over the past decade. Eligible women are required to enroll in Medicaid to receive benefits, and some states have recently created policies to simplify enrollment procedures for pregnant women (Hill et al., 2009; Ranji et al., 2009). However, the number of states that have increased outreach efforts and/or offered enhanced maternal benefits packages has declined slightly since the 1990s (Hill et al., 2009). Our analysis indicated a relative increase in Medicaid coverage reported by pregnant women, compared with similar women who are not pregnant. This finding is consistent with recent efforts to expand access to state Medicaid programs for pregnant women (through increased income eligibility or simplified enrollment) as well as greater numbers of women qualifying via income eligibility owing to the recent economic recession (Kaiser Family Foundation, 2010b; Markus & Rosenbaum, 2010).

A woman's eligibility for Medicaid coverage as a result of pregnancy ends 60 days after delivery, and as such, many women move in and out of insurance coverage, a process often described as "churning" (Ranji et al., 2009; Sommers & Rosenbaum, 2011). Although this phenomenon is not directly studied in our analysis, the discrepancy between the percentage of pregnant women who reported prior uninsurance (25%) and the percentage of pregnant women who reported currently having no insurance (10%) is consistent with the concept of "churning."

Not surprisingly, we identified declines in private health insurance coverage and availability of employer-sponsored coverage for reproductive-age women in the United States, consistent with those reported for the general population (Kaiser Family Foundation and Health Research and Educational Trust, 2010).

Although our study makes use of a rich, unique data source, secondary analysis of survey data is subject to a number of important limitations, based on data availability and measurement. Although we were able to identify pregnant women in the study, the NHIS survey did not collect specific information related to gestational age or maternity-related care that may be relevant for enhancing interpretation of the changes in health insurance coverage documented in this analysis. People under age 18 are not included in the NHIS survey, and it does not collect data on whether an individual has health insurance through a spouse. Also, imputation techniques are used by IHIS for some income data, and policy analysis was challenging because available income data do not correspond directly with FPL designations or associated policy aspects of the ACA. On balance, however, the strengths of sample size and national representativeness outweigh the limitations of the data source in allowing examination of health insurance trends among reproductive-age women.

Policy Implications

Our findings reveal important differences in levels and trends of health insurance coverage between pregnant and nonpregnant women of reproductive age. Due in part to eligibility for state Medicaid programs, pregnant women were more insulated from rising rates of uninsurance owing to general declines in private coverage. However, the magnitude and trends in the

Table 3
Selected State-Level Medicaid Policy Decisions that May Impact Health Insurance Coverage for Pregnant and Reproductive-Age Women

	2009 Status Across Surveyed States
Eligibility	
Income eligibility limit for pregnant women (% FPL)	Range, 133%–300% FPL
Enrollment	
No asset test	36/44 states and DC
Continuous coverage through 60 days postpartum	42/44 states and DC
Presumptive eligibility	25/44 states and DC
Application	
Short application form	35/44 states and DC
Forms accepted at alternate sites	49/44 states and DC
Eligibility workers at alternate sites	31/44 states and DC
Combined application form	37/44 states
Mail-in application	39/44 states and DC
Multilingual forms	36/44 states and DC

Abbreviation: FPL, federal poverty level.

Source: Ranji, U., Salganicoff, A., Stewart, A.M., Cox, M., Doamekpor, L. (2009). *State Medicaid Coverage of Perinatal Health Services Summary of State Survey Findings*. Kaiser Family Foundation and the George Washington University Medical Center School of Public Health. Available at: <http://www.kff.org/womenshealth/upload/8014.pdf>

number of all reproductive-age women (regardless of current pregnancy status) who report being uninsured or having gone without health insurance in the prior year is troubling.

Recognizing that half of pregnancies in the United States are unplanned or mistimed, the federal preconception care initiative aims to reach all women of reproductive age, regardless of their pregnancy intentions (CDC, 2006). Although changes to insurance access after health reform are likely to affect pregnant and nonpregnant groups differently, future increases in health insurance coverage facilitated by the ACA may potentially contribute to broad improvements in maternal and reproductive health, given the established connection between coverage and access to services (Hadley, 2003; Kaestner, 1999).

An important potential benefit of the ACA is that it will likely mitigate rising trends in uninsurance among reproductive-age women. The creation of an income floor for Medicaid eligibility may lead to improved continuity of Medicaid coverage for low-income women between pregnancies, including those who previously may have lost access to coverage after childbirth (Johnson, 2010; Sakala, 2010). State-based exchanges, preexisting condition exclusions, and subsidies may offer new private coverage options to pregnant and reproductive-age women, and preventive services coverage requirements may enhance available benefits for this population. For example, the ACA includes provisions that went into effect in 2010 to eliminate cost sharing for certain preventive services, including well-woman visits and support for breastfeeding (Kaiser Family Foundation, 2011b). Starting in 2012, new health plans will additionally cover a wide range of women's preventive services, including FDA-approved prescription contraceptives and screening for sexually transmitted infections, gestational diabetes, and intimate partner violence (Kaiser Family Foundation, 2011b).

While the ACA attempts to increase access to health insurance and improve the health of Americans, there are a few notable issues and exceptions that affect reproductive-age women. Undocumented immigrants are not eligible for Medicaid or premium subsidies under the ACA. An estimated 340,000 women without authorized legal status give birth every year in the United States, and the potential challenges presented by this issue will affect some states considerably more than others (Passell & Taylor, 2010). Further, it is likely that some women of reproductive age will remain uninsured after ACA implementation because coverage is unaffordable to them. For example, this could occur because their incomes do not qualify them for federal or state premium subsidies or because they have an offer of health insurance through their employer, but the out-of-pocket premiums are not perceived to be affordable. Under reform, each state's Medicaid program will still have differential eligibility criteria for pregnant women. Logistical challenges presented by changes in eligibility or coverage status and "churning" between or among public and private plans may persist as reproductive-age women and others may move more frequently between Medicaid programs and insurance offered through state-based exchanges (Sommers & Rosenbaum, 2011). Clinicians who care for pregnant and reproductive-age women should be aware of these issues and how they may affect the patient populations they serve, and policy makers ought to ensure that monitoring and evaluation of the ACA include examination of potential unintended consequences for this population.

Careful attention is required, as ACA implementation progresses, to ensure access to appropriate preconception and prenatal health care services. A preponderance of evidence supports the role of prenatal care conferring important maternal

and infant health benefits, including reduction of perinatal mortality (Alexander & Kotelchuck, 2001; Fiscella, 1995). For example, infants born to mothers who received no prenatal care have lower birth weights and higher rates of admission to neonatal intensive care units (Friedman, Heneghan, & Rosenthal, 2009). Care before pregnancy is also critically important for maternal and infant health (Atrash, Johnson, Adams, Cordero, & Howse, 2006). Preconception care is an increasing focus of clinical and policy attention, including consideration of the importance of insurance coverage in facilitating access to care (CDC, 2006; Rosenbaum, 2008). Policymakers and clinicians who care for reproductive-age women should be aware of changing patterns in access to health insurance and periods of uninsurance and how this may impact timely and appropriate prenatal and preconception care. Continuous monitoring of insurance trends among reproductive-age and pregnant women will be critical to understanding how changes in health insurance regulations, access, benefits, and mandates affect this population.

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